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Kansas Department of Health and Environment

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Authorization for Dispensing Medications to Children or Youth **Short-Term Medications (Prescription and Non-Prescription)**

Prescription medications must be in their original containers labeled with the child's or youth's first and last name, the date the prescription was filled, the name of the licensed physician or licensed nurse practitioner who wrote the prescription, the expiration date of the medication, and specific and legible instructions for administration and storage of the medication. Administer the medication according to the instructions. Non-prescription medications can be given by permission and direction from the parent, guardian or legal custodian based on general advice received from the child's or youth's physician. Administer nonprescription medication from the original container labeled with the first and last name of the child or youth and according to the instructions on the label. A record of administration must be kept.

Medication #1					
First and Last Name of Child or Youth					
Name of Me	Name of Medication				
Reason for Medication					
Dose	Time to be Given	Stop Date			
Name of Licensed Physician/Nurse Practitioner prescribing the medication ()					
Phone number of Health Care Provider					
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.					
Parent's Sig	gnature	Date			

Medication #2				
First and Last Name of Child or Youth				
Name of Medication				
Reason for Medication				
Dose Time to be Given	Stop Date			
Name of Licensed Physician/Nurse Practitioner prescribing the medication				
Phone number of Health Care Provider				
I allow the above medication to be given to my child or youth by the child care provider/staff member or school age program staff member.				
Parent's Signature	Date			

THIS FORM IS TO BE USED TO DOCUMENT ADMINISTRATION OF ONLY THE MEDICATION(S) IDENTIFIED ABOVE. Provider or staff member to note any comments or remarks about the child's or youth's appearance on the back of this form.

Date mm/dd/yy	Time	Name of Medication Given to Child	*Initials	Date mm/dd/yy	Time	Name of Medication Given to Child	*Initials

Each person administering medication is to sign on the back side of this form and identify initials used above.

Signature of	of Person Administering Medication	Initialing as			
Signature of	of Person Administering Medication	Initialing as			
Signature of Person Administering Medication		Initialing as			
	Note Form				
Date	Comments about the incident or other related incidents, including remarks about the child's or youth's appearance.				
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*Signature of Person Administering Medication ______ Initialing as_____